2008 City of Rockville Summary of Health Plan Benefits

	CareFirst Blue Choice- HMO	Kaiser Permanente Health Plan - HMO	M.D. IPA Plan - HMO	M.D. IPA Plan – Point of Service (POS)
This summary of benefits is provided to highlight the benefits offered by the various health plans. ***Please refer to each plan's brochure for detailed information or contact the member services department to discuss specific benefits and exclusions.*** ***The plan contracts are the binding and overriding documents in matters of benefits and coverage. Any dispute arising from a variance between this document and the plan contracts shall be settled according to the provisions of the plan contract.***	**PLAN DESCRIPTION** CareFirst offers a network of over 25,000 participating providers and 66 hospitals. The Primary Care Physician selected serves as a coordinator of medical care. This care includes specialist referrals and hospitalizations. Except in emergencies, members must use participating providers and hospitals to qualify for coverage. **ELIGIBILITY** EMPLOYEE - Eligibility begins on the date of hire for regular employees. DEPENDENTS – Spouses and unmarried dependent children under age 25 are eligible for coverage. Unmarried dependent children over age 25 who are full-time students in an accredited college, university, or trade school are eligible for coverage until age 26.	**PLAN DESCRIPTION** Kaiser Permanente's traditional closed model HMO provides a totally integrated health care delivery system, where members receive comprehensive health care primarily at Kaiser Permanente facilities. Kaiser believes that by providing services through this integrated system, optimal levels of continuity and appropriate care are achieved. Physicians work as a team while practicing at Kaiser Permanente's multi-specialty Medical Centers and caring exclusively for Kaiser Permanente members. Kaiser Permanente operates 29 medical facilities in the Washington, DC, N. Virginia & Baltimore metropolitan area. **ELIGIBILITY** EMPLOYEE - Eligibility begins on the date of hire for regular employees. DEPENDENTS - Spouses and unmarried dependent children under age 26 are eligible for coverage. Unmarried dependent children under age 26 whom the subscriber or their spouse claims as an exemption on his/her Federal income tax return and permanently resides in the subscriber's household are also eligible for coverage.	**PLAN DESCRIPTION** The M.D.IPA HMO Plan offers a network of over 21,000 providers and 158 hospitals throughout the Maryland, Washington, DC, Virginia, and select counties in VA. Upon joining the Plan, the member chooses a Primary Care Physician (PCP) who acts as a "gatekeeper" for the member to access health care benefits. The PCP, when necessary, will refer the member to participating specialists and hospitals. Routine dental care and routine gynecological visits are allowed on a self-referral basis to participating providers. **ELIGIBILITY** EMPLOYEE – Eligibility begins on the date of hire for regular employees. DEPENDENTS - Spouses and unmarried dependent children under age 25 are eligible for coverage. Unmarried dependent children over age 25 who are full-time students (not less than 12 credit hours a semester) in a recognized college, university or trade school are eligible for coverage until the end of the month in which they turn age 26.	**PLAN DESCRIPTION** Under the M.D. IPA Point of Service (POS) Plan, members have the option to receive medical care from providers in the M.D. IPA HMO Plan or from non-participating providers. • **In-Plan** care is provided by the designated M.D. IPA primary care physician (PCP) with referrals to specialists made by this PCP. • **Self-Referral** care is provided by the M.D. IPA HMO network of providers. Most allowable medical care expenses are covered at 80% of the Plan's Fee Schedule with members paying 20% after annual deductible. • **Out-of-Plan** care is provided by non-participating providers. Most allowable medical expenses are covered at 80% of the UCR charge with members paying 20% after annual deductible. Note: Some medical services are only covered In-Plan. **ANNUAL DEDUCTIBLES** **$300 for Individual coverage, $600 for 2-Party and Family coverage.** **ELIGIBILITY** Same as M.D. IPA HMO (see previous column).

	CAREFIRST BLUE CHOICE- HMO	KAISER PERMANENTE HEALTH PLAN - HMO	M.D. IPA PLAN - HMO	M.D. IPA PLAN – POINT OF SERVICE (POS)
ALCOHOL, DRUG AND SUBSTANCE ABUSE TREATMENT	Services are provided for assessment, crisis intervention, and therapy as approved by the health plan. Substance abuse treatment is part of Mental Health treatment. **Inpatient Treatment:** Full coverage. **Outpatient Treatment:** Unlimited visits with the following cost sharing: • Visits 1 to 5 per calendar year, 20% of plan allowance. • Visits 6 to 30 per calendar year, 35% of plan allowance. • Visits in excess of 30 per calendar year, 50% of plan allowance.	Full coverage when found medically appropriate by the Plan. Benefits are combined with Mental Health benefits. **Inpatient Treatment:** Full Coverage. Unlimited days **Outpatient Treatment:** • Individual Visits - $20 per visit • Group Visits - $10 per visit.	**Inpatient Facility:** Unlimited days, full coverage. $25 copay-partial hospitalization-60 day limit **Outpatient Treatment:** Unlimited visits with the following cost sharing: • Visits 1 to 5 per calendar year, 20% of total charges. • Visits 6 to 30 per calendar year, 35% of total charges. • Visits in excess of 30 per calendar year, 50% of total charges.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/Out-of-Plan:** Pre-certification by health plan utilization review dept. required for inpatient treatment to be covered. **Self-Referral/Out-of-Plan:** **Inpatient Treatment:** Member pays 20% coinsurance per admission after deductible. **Self-Referral/Out-of-Plan:** **Outpatient Treatment:** Unlimited visits with the following cost sharing after deductible: • Visits 1 to 5 per calendar year, 20% of plan allowance. • Visits 6 to 30 per calendar year, 35% of plan allowance. • Visits in excess of 30 per calendar year, 50% of plan allowance.
ALLERGY	**Referral required to see Specialist** $20 copay – Primary Care $30 copay - Specialist	Primary Care Physician - $10 copay per office visit Children under 5 – no copay Injections – $10 copay	• $10 copay for Primary Care Physician visits. • $15 copay for Specialist visits.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In and Out-of-Plan:** Member pays 20% after annual deductible. • All allergy sera 20% coinsurance.
AMBULANCE SERVICES	Full coverage when medically necessary	Full coverage, in emergency situations and when ordered by Kaiser Permanente physicians.	Full coverage when found medically necessary by plan.	80% when found medically necessary by plan.
ANESTHESIA	Full coverage	Full coverage	Inpatient – 100% covered. Dental related: See Dental Care	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/Out-of-Plan:** Member pays 20% after annual deductible.
BIRTH DEFECTS TREATMENT	Inpatient Hospitalization: 100% covered. $20 copay for office visits occupational, physical and speech therapy. Habilitative services for children under age 19 with congenital & genetic birth defects to enhance the child's ability to function.	Full coverage, when services and treatment are found medically necessary by the Plan and not specifically excluded.	Inpatient Hospitalization: 100% covered. $15 copay for office visits occupational, physical and speech therapy. Habilitative services for children under age 19 with congenital & genetic birth defects to enhance the child's ability to function.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In/Out-of-Plan:** 20% after annual deductible. Habilitative services for children under age 19 with congenital & genetic birth defects to enhance the child's ability to function.

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CHIROPRACTIC CARE	Primary Care Physician referral required. 20 visits maximum - $30 copay per visit	20 visit maximum - $15 copay per visit.	50% co-payment - $500 limit per contract year Acupuncture services: 12 visit max per year for approved conditions-$15 copay	**In-Plan/Out-of Plan**- 50% reimbursement of charges - $500 limit per contract year. Deductible applies out-of-plan. Acupuncture services: 12 visit max per year for approved conditions.
COSMETIC SURGERY	Not Covered	See Surgery	Not Covered	Not Covered
DENTAL CARE AND DENTAL SURGERY	**Dental Care:** There is a discounted dental program. **Dental Surgery:** Full coverage for accidental injury when authorized by health plan.	**Dental Care:** There is a discounted dental program. **Dental Surgery:** Full coverage for accidental injury when authorized by health plan. Subject to $10 office visit copayment.	**Dental Care:** There is a discounted dental program. **Dental Surgery:** Covered if related to an accidental injury. Pre-certification required for general anesthesia services related to a dental procedure.	**In Plan only**
DURABLE MEDICAL EQUIPMENT	25% of plan allowance up to a total plan payment of $7500.	No Charge-for Medicare approved DME after authorized confinement to a hospital, a skilled nursing facility, a rehabilitation facility or outpatient surgery.	50% copay of total charges. 15 month cap on most rental items. Health Plan determines the rental, repair or purchase of requested items. Excluded: Scooters, seat lifts & lift mechanisms, wax treatment/paraffin baths, over the counter medical/first aid equipment/supplies.	**Self-Referral-In/out of the Plan** 50% coinsurance deductible applies out-of-plan.
DOCTOR'S OFFICE VISITS	$20 copay for Primary Care Physicians. $30 copay for Specialist	$10 office visits copay. Copay waived for children under age 5-non Specialist	$10 copay for Primary Care Physician visits. $15 copay for Specialist visits.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral In-Plan /Out-of-Plan:** Member pays 20% after annual deductible.
EMERGENCY ROOM VISITS (NOT RESULTING IN A HOS-PITAL ADMISSION)	• $50 copay per emergency room visit (copay waived if admitted). • $20 copay at Primary Care Physician office or $30 copay at Specialist office or participating Urgent Care Center.	$50 emergency room copay.	$25 copay per Emergency Room visit for services that meet the Plan's definition of emergency services. Treatment of conditions that do not meet the Plan's definition of an emergency are not covered.	**In-Plan:** Same as M.D. IPA HMO.
HEALTH EDUCATION CLASSES	Full coverage for those offered by CareFirst Disease Management Program.	Small fee may be charged depending on class being offered.	Full coverage for those offered by the plan.	**In Plan ONLY** -Full coverage for those offered by the health plan.
HOME HEALTH CARE	Full coverage	Full coverage	100% covered after physician home copay.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral In-Plan /Out-of-Plan:** 20% coinsurance

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HOSPICE CARE	Full coverage	Full coverage	Full coverage. 30 days inpatient; 15 visits during 6 month period for bereavement counseling.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In Plan/Out-of-Plan**: 20% coinsurance after deductible. 30 days inpatient; 15 visits during 6 month period for bereavement counseling.
HOSPITAL (INPATIENT)	Full coverage	Full coverage when authorized or approved by health plan.	Full coverage	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In Plan/Out-of-Plan** pays 20% coinsurance.
IMMUNIZATIONS (PREVENTIVE)	$20 copay Primary Care Physician; $30 copay Specialist.	Full coverage. $10 office visits copay.	$10 copay for Primary Care Physician visits. $15 copay for Specialist visits.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible.
INJECTIONS	Full coverage. $20 copay at Primary Care Physician office. $30 copay at Specialist office.	Full coverage. $10 office visit copayment.	$10 copay at Primary Care Physician office. $15 copay at Specialist office.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible
INTENSIVE CARE	Full coverage	Full coverage when authorized/approved by health plan.	Full coverage	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible.
LABORATORY, DIAGNOSTIC, THERAPEUTIC, ELECTRO-CARDIO-GRAM, X-RAY, ETC.	Full coverage	Laboratory and X-ray, no charge Therapeutic and ultrasound, $10 office visit copayment.	Laboratory: Full coverage at participating lab, after copay.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible, per visit.
MATERNITY CARE	$30 copay per visit Delivery, hospitalization and nursery charges covered in full.	Full coverage for office visits and delivery Outpatient prenatal visits and outpatient postnatal visit – No Charge	$15 copay Delivery, hospitalization and nursery charges covered in full	**In-Plan:** See M.D. IPA HMO. **Self-Referral/Out-of-Plan:** Member pays 20% after annual deductible.

	CAREFIRST BLUE CHOICE- HMO	KAISER PERMANENTE HEALTH PLAN - HMO	M.D. IPA PLAN - HMO	M.D. IPA PLAN – POINT OF SERVICE (POS)
MENTAL HEALTH	Services are provided for assessment, crisis intervention, and therapy as approved by the health plan. Substance Abuse treatment is part of Mental Health treatment. **Inpatient Treatment** - No copay **Outpatient Treatment:** • Unlimited visits with the following cost sharing: • Visits 1 to 5 per calendar year, 20% of plan allowance • Visits 6 to 30 per calendar year, 35% of plan allowance • Visits in excess of 30 per calendar year, 50% of plan allowance	Full coverage when found medically necessary by the Plan. Benefit is combined with CD benefits. Unlimited days. **Inpatient Treatment:** No copay when services provided through the Plans managed care system. **Outpatient Treatment:** •$20 per individual therapy visit •$10 per group therapy visit	**Inpatient Facility:** Unlimited days, full coverage. **Partial hospitalization Treatment:** $25 copayment per day-max 60 days per year **Patient payments:** •Visits 1 to 5 per calendar year, 20% of total charges •Visits 6 to 30 per calendar year, 35% of total charges •Visits in excess of 30 per calendar year, 50% of total charges	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/Out-of-Plan:** **Inpatient Treatment** - must be pre-certified by plan. 20% after deductible per admission **Outpatient Treatment:** Unlimited visits. **Patient payments:** •Visits 1 to 5 per calendar year, 20% of total charges. • Visits 6 to 30 per calendar year, 35% of total charges. • Visits in excess of 30 per calendar year, 50% of total charges.
OB/GYN (Also see MATERNITY)	OB Full coverage for pregnancy - Plan allows self-referral for GYN visits with a participating GYN - $20 copay. Care shall be medically necessary but not limited to routine care. In-vitro fertilization covered at 50% - Limitations: 3 attempts per live birth. $100,000 maximum lifetime benefit.	Full coverage. In-vitro fertilization covered at 50% of allowable charges - Limitations: 3 attempts per live birth. $100,000 maximum lifetime benefit. Infertility – 50% copay	Female members have direct access to a participating GYN without referral from PCP. Care shall be medically necessary, Including, but not limited to, routine care In-vitro fertilization covered at 50% - Limitations: 3 attempts per live birth. $100,000 maximum lifetime benefit • $15 copay for Specialist visit.	**Self-Referral/In-Plan:** OB/GYN same as HMO. **Self-Referral/Out-of-Plan** - 20% after deductible for OB/GYN
OPHTHALMOLOGY	$25 copay for routine annual visit. (referral required)	$10 office visit for routine eye exams and refraction exams	$25 copay for annual eye refraction exam (regular vision test). Discounts are available at participating optical centers.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/Out-of-Plan:** Member pays 20% after annual deductible.
OPTOMETRY	Full coverage including refraction exams (vision tests) for eyeglasses. Members receive discounts at participating optom-etrists/opticians on lenses, frames, and contact lenses. $30 copay.	25% off the cost of lenses and frames at a Kaiser Optical shop only. 15% off the cost of contact lenses. Discount on contact lenses at a Kaiser Optical shop only.	$25 copay for eye refraction exam. Members receive discounts on eye-wear at participating opticians/ optometrists.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/Out-of--Plan:** Member pays 20% after annual deductible.
OUT OF AREA/ COUNTRY CARE	See Emergency Room Visits. The Plan must be notified within 48 hours of hospital admission.	Full coverage for hospital and physician services for unforeseen urgent or emer-gency conditions. Urgent Care - $10 copay	Not covered except for emergency services. The Plan must be notified within 48 hours of admission. $25 emergency room copay.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/Out-of-Plan:** Member pays 20% after annual deductible, if not a true emergency

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PEDIATRIC CARE	$20 copay for Primary Care Physician visits. $30 copay for Specialist visits.	Full coverage. No copayment up to age 5; $10 office visit copayment.	$10 copay for Primary Care Physician visits. $15 copay for Specialist visits.	**Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible.
PHYSICAL THERAPY	Referral required from Primary Care Physician Limited to 30 visits per condition, per calendar year. $30 copayment for Specialist	Outpatient services - $10 copay applies. Occupational & Speech Therapy = 90 days Physical Therapy = 30 visits	Up to 60 visits per condition. $15 copay for Specialist visits. Limits are combined with the limits stated under Speech/Occupational Therapy.	**Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible up to 60 visits or 60 days for treatment of conditions subject to significant improvement.
PHYSICIAN SERVICES (IN HOSPITAL)	Full coverage	Full coverage	Full coverage	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible.
PRENATAL AND POSTNATAL CARE	Full coverage	Full coverage once pregnancy is diagnosed. No charge through delivery and first postnatal visit, $10 per visit thereafter.	$15 copay	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/Out-of-Plan:** Member pays 20% after annual deductible.
PRESCRIPTION DRUGS	• $10 generic drug copay at participating pharmacies. • $20 preferred brand drug copay at participating pharmacies. • $35 for non-preferred brand name drug.	• $10/20 copay per Rx at Kaiser Permanente pharmacies. • $16/32 copay per Rx at Rite Aid, Giant, CVS, Safeway and other participating pharmacies. • $10/20 copay per Rx for mail order program.	• $5 generic drug copay per prescription at participating pharmacies. • $10 brand name drug copay per prescription at participating pharmacies. • Same 3 copay for a 90-day supply through a mail order program.	**In-Plan coverage:** See M.D. IPA HMO. **Out-of-Plan:** 20% copayment
PREVENTIVE CARE	$20 copay Primary Care Physician $30 copay Specialist	Full coverage. $10 office visit copay	• $10 copay for Primary Care Physician visits. • $15 copay for Specialist visits.	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/ /Out-of –Plan:** 20% coinsurance after deductible.
PRIVATE DUTY NURSING CARE	Full coverage if ordered by health plan doctor.	Full coverage when found medically necessary and ordered by the Plan.	Not covered	**In-Plan:** Same as M.D. IPA HMO. **Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible with pre-certification by health plan utilization review dept.

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PROSTHETICS	See Durable Medical Equipment. 1 hair prosthesis per calendar year for hair loss resulting from chemotherapy or radiation treatment for cancer (not to exceed $350.00)	Full coverage for specific devices. See Plan contract or call Member Services for details.	50% copay for durable medical equipment. Prosthetic limbs limited to l initial & 1 permanent p/limb. 1 hair prosthesis per lifetime for hair loss resulting from chemotherapy or radiation treatment for cancer (not to exceed $350.00)	**In-Plan**: Same as M.D. IPA HMO. **Out-of-Plan**: 50% after annual deductible.
SKILLED NURSING CARE	Full coverage	Full coverage when found medically necessary by the plan. Up to 100 days per calendar year.	Full coverage for up to 60 days per calendar year.	**In-Plan**: Same as M.D. IPA HMO. **Self-Referral/In-Plan/Out-of-Plan** – 20% coinsurance after annual deductible.
SURGERY	Full coverage **Cosmetic Surgery**: • See Cosmetic Surgery. **Dental Surgery:** • See Dental.	Full coverage for Outpatient and Inpatient-$10 copay **Cosmetic Surgery**: • Full coverage if found medically necessary by the plan. **Dental Surgery:** • Full coverage for accidental injury when authorized by the Plan. See Dental.	Full coverage for inpatient surgery. • $15 Specialist copay for in-office treatment. • $25 copay for Outpatient Hospital treatment. **Cosmetic Surgery**: Not Covered **Dental Surgery:** • See Dental.	**In-Plan**: Same as M.D. IPA HMO. **Self-Referral/In-Plan/Out-of-Plan:** Member pays 20% after annual deductible with pre-certification from health plan utilization review dept. **Cosmetic Surgery - See Cosmetic Surgery.**: **Dental Surgery:** •See Dental.
TRANSPLANTS	When medically necessary, the following transplants are covered: cornea, bone, skin, kidney, liver, bone-marrow	Inpatient care – No charge Office Visits - $10 copay	When medically necessary, the following transplants are covered: heart, heart/lung, pancreas, lung, liver, kidney, cornea and all non-experimental bone-marrow	When medically necessary and approved by the Plan, the following are covered 80%: heart, heart-lung, liver, lung, pancreas, kidney, cornea and non-experimental bone marrow
VISION	See Ophthalmology and Optometry. Members receive discounts on eyeglasses at participating providers.	See Ophthalmology and Optometry.	See Ophthalmology and Optometry. $25 copay for Eye Refraction Exam. One annual visit.	See and Optometry and Ophthalmology
X-RAY	See Laboratory, Diagnostic, etc.	See Laboratory, Diagnostic, etc.	See Laboratory, Diagnostic, etc.	See Laboratory, Diagnostic, etc.

	CAREFIRST BLUE CHOICE- HMO	KAISER PERMANENTE HEALTH PLAN - HMO	M.D. IPA PLAN - HMO	M.D. IPA PLAN – POINT OF SERVICE (POS)
ADDITIONAL FEATURES	• ***CareFirst*** quarterly news-letter. • ***Care Management Program*** for members with diabetes, asthma, heart disease, cancer • ***CareFirst Option*** – discount program for acupuncture, massage therapy, chiropractic care, fitness centers, personal trainers, spas and yoga • **Online Healthcare**- healthcare guides offer information on nutrition, fitness, chronic illnesses, stress, mental health and more • **First Help** - 24-hour nurse assistance for urgent and routine medical questions: 1-800-535-9700	• ***Partners in Health*** quarterly newsletter. • Healthwise Handbook and Medical Services Guide. • "Be Well" Health Education Classes: -Child Birth Preparation (Lamaze) -Healthy Toddlers -Living with Diabetes -Managing Blood Pressure -Prenatal Care • **Healthphone** - 24-hour line of recorded health messages: 1-800-332-7563. • **Medical Advice/Appointment line** - 24-hour nurse assistance for urgent and routine medical questions: 1-800-777-7904	• ***HealthSense*** quarterly newsletter. • Asthma Disease Management program. • Diabetes Disease Management program. • Cardiovascular Management Program • **"Timely Tots"** - This is a voluntary pregnancy education program available to all expectant mothers at no additional charge. The member also has access to a 24-hour hotline for questions and receives monthly educational materials.	**In-Plan coverage only** - See M.D. IPA HMO.